Using the Enter new document icon in the toolbar, manually type in one of the following notes:

- Pediatric Initial Patient Evaluation (replaces paper Pediatric Initial Patient Evaluation)
- Pediatric Routine Care Visit (replaces Pediatric Ambulatory Progress Note)
- Pediatric Episodic Care Visit (replaces Ambulatory Progress Note)

After selecting the note, double click to open and begin filling in the fields or checkboxes.

*The left panel contains each observation header. To the right is the data entry section.*

- If you see a **blue exclamation** point it means the document will be submitted as incomplete unless you fill out that section. A warning message will appear upon clicking Submit.

- A **red star** is a mandatory section. The note cannot be submitted unless that section is filled in.

- In order to move from one section to the next you must click on the **Next** button on the bottom of the screen. Or you can click on each header name in the left panel.
TRIAGE NOTE

To view the Triage note filled out by nursing, click on the Observation section “Triage Note”.

You can view the Growth Chart information or click on the Pediatric Triage Note for Vitals, Reason for Visit, Pain Assessment, etc. If you would like to include the Triage Note or Growth Chart as part of your submitted note check the box at the top with today’s date.

Please note: this is a view only section pulled in from the Nursing Triage Flowsheet.

DEVLOPMENTAL MILESTONES

Milestones are listed from 1 month to 11-14 years. You only need to choose the one that is age appropriate. Selecting “Meets all of the following” will summarize all milestones on your final note.
In the **Review of systems**, if you want to check off all negative, select the first negative. At the bottom left hand of the screen click Auto Enter Section and it will select negatives.

**Please note:** Use the same methodology for “normals” on the Physical Exam.

If you see a button selection with 3 dots after it that means there is more to choose from and if you select it more buttons will populate.

**Please note:** Round buttons mean you choose one or the other. Square check boxes are multiple select, you can choose more than one.
If you would like to **Review** the document while you are filling it out, click on the Review button on the bottom right side of the screen.

![Review Button]

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**Revised 2/28/08 DA**

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**Reason For Visit/Chief Complaint**
- **Reason For Visit**: Initial Routine Visit

**Developmental Milestones**
- **1 Month**: Smiles spontaneously, looks at caregiver's face, responds to sound, lifts head, movements equal.

**Histories**
- **Patient's Medical History**: Review
- **Allergies**: Yes

**Review of Systems**
- **General**: Positive...
- **Nose/Sinus**: Discharge
- **Pharynx**: No discharge

**Physical Exam**
- **General**: Well-developed, well-nourished, no acute distress, alert, active, arithmetic
- **Skin**: Normal tone, turgor, texture
- **Head**: Symmetrical, no asymmetricity
- **Eyes**: Vision normal,.parentNode:Documents/7:1:12

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If you need to see other information for the patient in SCM you can **HIDE** the document and come back to it.

Click on the **Hide** button at the bottom right side of the note. And then to get back into the current note to continue documenting, click on the **Enter Document** icon in the toolbar again.
FOR RESIDENTS ONLY:

When finished writing your note, check off the **Incomplete** button at the top of the screen and **Click Submit**. The attending will go back into the document to review and sign the provider statement.

EDIT OR APPEND A DOCUMENT

Go to the Documents Tab, click on the note and then right click and choose Edit Document.

*Please note: you can only edit before the Attending has signed off on it, if you need to add an addendum after the Attending has signed off on it you need to right click and choose Append Document*
FOR ATTENDINGS REVIEWING RESIDENTS’ NOTES ONLY:

To review a document, the attending can go to the Documents tab, highlight the correct document, and double click on it.

To sign off from the Documents Tab, right click on the document, select Edit document. Check off the appropriate Provider Statement and then uncheck the incomplete box.

Use the Review button to view the full attestation.
REVIEWING A DOCUMENT

Go to the Documents tab, highlight the correct document, and double click on it.

Use the sort sequence area at the bottom of the screen to change the view (i.e. date to author).

REFER TO NOTE

If you would like to reference a section of a previous note inside your own note, click on Refer to Note. Choose the note on the left hand side that you would like to reference. In the middle, select the sections of the note that you would like to reference. Click “Reference Items in Note”.

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The icon that looks like books 📖 will appear in your note in the section you used the Refer to Note for. The information will copy into your note.

<table>
<thead>
<tr>
<th>Patient's Medical History</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies Reviewed?</td>
<td>☑ Yes</td>
</tr>
<tr>
<td>History of Anaphylaxis?</td>
<td>☑ Yes, ☐ No</td>
</tr>
<tr>
<td>Immunizations:</td>
<td>☑ UTD, ☑ Delayed</td>
</tr>
<tr>
<td>Patient's Medical History:</td>
<td>☑ positive, ☐ negative, ☐ unknown</td>
</tr>
<tr>
<td>Surgical History</td>
<td></td>
</tr>
</tbody>
</table>

- Date of Menarche:   
- Date of LMP:        
- Date of Last Dental Exam: 

Your final note will show that you referenced information from another note.

**Visit**

**Histories**

- **Patient's Medical History:** Data referenced from "Pediatric Initial Patient Evaluation" 03/19/2008 8:04 AM
  - Allergies Reviewed?: Yes
  - Immunizations: Delayed

- **Social:** Data referenced from "Pediatric Initial Patient Evaluation" 03/19/2008 8:04 AM
  - Country of Birth: U.S.A.
  - Guardian: parents

**Signatures**

- [Signature] (Physician's Signature)